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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Oct/13/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Epidural Steroid Injection at L4-S1

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 08/27/09, 08/12/09
Left Shoulder MRI: 10/13/08
Letter for Claims Representative: 11/26/08
CT scan of Temporal Bones; CT scan of Mandible: 02/19/09
MRI Cervical Spine: 02/20/09
Dr. – Authorization Request for lumbar ESI: 04/24/09; 06/01/09
MRI Lt. Shoulder & Lt. shoulder X-Rays: 04/30/09
Dr. – statement of medical necessity & computerized ROM/MMT findings: 03/19/09; 06/08/09; 09/15/09
Surgery Reservation Sheet/UR Notification – Lt. shoulder arthroscopy, SAD: 08/13/09
Letter from (claimant's attorney): 09/25/09
Medical Printouts/Literature on lumbar ESIs
Initial report, Dr. 08/25/08
MRI lumbar spine, 09/25/08
Independent Medical Evaluation, Dr., 11/12/08
Office note, Dr., 01/06/09
Ortho Consult, Dr., 03/19/09
Office notes, Dr., 04/07/09, 05/05/09
Office notes, Dr. , 06/08/09, 06/08/09, 07/30/09, 09/15/09

Procedure Orders, Dr., 08/06/09

PATIENT CLINICAL HISTORY SUMMARY
This male sustained multiple injuries on xx/xx/xx. He was treated and released from the emergency room following his injury with a current diagnosis of left shoulder impingement and herniated nucleus pulposus at L4-5 and L5-S1. A lumbar MRI dated 09/25/08 revealed small disc herniations at the L4-5 and L5-S1 levels. He was evaluated by Dr. on 02/11/09 who determined him to have a severe single episode major depressive disorder with chronic severe pain disorder and posttraumatic stress disorder. Individual and group medical psychotherapy and medical biofeedback training were recommended. Records revealed the claimant underwent one lumbar epidural steroid injection on an unknown date with 50 to 60 percent relief. The 09/15/09 exam demonstrated mild tenderness to palpation in the lower lumbar spine with decreased flexion and extension limited by pain. Dr. requested authorization to proceed with a second lumbar epidural steroid injection.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
When one turns to the medical records in this case, the diagnosis of radiculopathy is not clearly and reproducibly documented by physical findings. Although the first epidural findings reportedly produced fifty percent relief, there is no clear documentation as to the duration of such relief. Taking this into account and taking into account the ODG guidelines pertaining to epidural steroid injections the reviewer is unable to recommend as medically necessary the proposed Epidural Steroid Injection at L4-S1.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates: Low Back – Epidural steroid injections

Criteria for the use of Epidural steroid injections

1) Radiculopathy must be documented. Objective findings on examination need to be present.

2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)

3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance

Diagnostic Phase

1) At the time of initial use of an ESI a maximum of one to two injections should be performed.

2) A repeat block is not recommended if there is inadequate response to the first block.

3) A second block is also not indicated if the first block is accurately placed unless:

a. there is a question of the pain generator;

b. there was possibility of inaccurate placement; or

c. there is evidence of multilevel pathology

In these cases, a different level or approach might be proposed

There should be an interval of at least one to two weeks between injections

4) No more than two nerve root levels should be injected using transforaminal blocks

5) No more than one interlaminar level should be injected at one session

Therapeutic phase

1) If after the initial block/blocks are given and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be required

2) Indications for repeat blocks include acute exacerbation of pain, or new onset of symptoms. The general consensus recommendation is for no more than 4 blocks per region per year.

3) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response

4) Current research does not support a routine use of a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.

5) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment

Cervical and lumbar epidural steroid injection should not be performed on the same day.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)